



IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

November 8, 2006

FILE COPY

Robert Williams, Administrator
The Haven
1119 West Hudson Avenue
Nampa, ID 83651

License #: RC-832

Dear Mr. Williams:

On October 13, 2006, a complaint investigation, state licensure survey was conducted at The Haven. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.
- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted plan of correction and evidence of resolution.

Should you have questions, please contact Rebecca Winter, RN, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

REBECCA WINTER, RN
Health Facility Surveyor
Residential Community Care Program

RW/slc

c: Jamie Simpson, MBA, QMRP Supervisor, Residential Community Care Program



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October 26, 2006

CERTIFIED MAIL #: 7003 0500 0003 1967 1329

Robert Williams, Administrator
The Haven
1119 West Hudson Avenue
Nampa, ID 83651

FILE COPY

Dear Mr. Williams:

Based on the state licensure survey conducted by our staff at The Haven on **October 13, 2006**, we have determined that the facility failed to protect residents from inadequate care. Based on record review and interview it was determined the facility failed to develop an NSA or a BMP to identify and describe a resident's needs for 1 of 4 sampled residents (Resident #1).

This core issue deficiency substantially limits the capacity of The Haven to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **November 27, 2006**. **We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- ♦ What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- ♦ How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- ♦ What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- ♦ How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- ♦ What date will the corrective action(s) be completed by?

Robert Williams, Administrator
October 26, 2006
Page 2 of 2

Return the **signed** and **dated** Plan of Correction to us by **November 7, 2006**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

In accordance with Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Chief of the Bureau of Facility Standards for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**November 7, 2006**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for the Bureau of Facility Standards to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **November 7, 2006**, your request will not be granted.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **November 12, 2006**.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by The Haven.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,



JAMIE SIMPSON, MBA, QMRP
Supervisor
Residential Community Care Program

JS/slc

Enclosure

c: Debra Ransom, R.N., R.H.I.T., Chief, Bureau of Facility Standards
Lynne Denne, Program Manager, Regional Medicaid Services, Region III - DHW

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R832	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/13/2006
NAME OF PROVIDER OR SUPPLIER HAVEN, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1119 WEST HUDSON AVENUE NAMPA, ID 83651		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments The following deficiency was cited during a complaint investigation conducted at your residential care/assisted living facility. The surveyors conducting your survey were: Rebecca Winter, RN Team Coordinator Health Facility Surveyor Karen McDannel, RN Health Facility Surveyor Survey Definitions: UAI = Uniform Assessment Instrument NSA = Negotiated Service Agreement BMP = Behavior Management Plan	R 000	R 008 16.03.22.520 PROTECT RESIDENTS FROM INADEQUATE CARE. • THE ADMINISTRATOR HAS COMPLETED A NSA ON ALL RESIDENTS, INCLUDING RESIDENT #1, ALSO, A UAI, NSA, Plan of Care form has been done on Residents. I thru 6, clearly documenting proper direction to caregivers on how to intervene when the resident demonstrates inappropriate behavior(s).	
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: Based on record review and interview it was determined the facility failed to develop an NSA or a BMP to identify and describe resident's needs for 1 of 4 sampled residents (Resident #1). The findings include: A. NSA Review of Resident #1's record revealed the resident was admitted on 7/3/06 with diagnoses which included anxiety, depression and osteoporosis.	R 008	• A UAI, NSA, CARE PLAN has been implemented on all residents providing all caregivers on how to intervene when the resident(s) display inappropriate behavior. • Administrator will review any and all incident reports (if any) with caregivers assuring appropriate corrective action was taken. • Administrator will make sure all residents will have a completed UAI, NSA, Plan of Care, and will go over each one with caregiver.	

Bureau of Facility Standards

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

5599

T06711

If continuation sheet 1 of 4

Bureau of Facility Standards

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R 008	<p>Continued From page 1</p> <p>The resident's record contained a UAI, dated 7/31/06, which documented the resident required moderate assistance in the areas of eating meals, toileting, transferring, personal hygiene, dressing, finance, night needs and emergency response. The UAI further documented the resident required extensive assistance in the areas of mobility, bathing, shopping, and medications. The resident required total assistance with meal preparation, laundry and housework.</p> <p>Further review of the resident's record revealed there was no documented evidence of an NSA.</p> <p>On 10/12/06 at 12:05 p.m., the resident was observed being assisted with her medications while she sat at the dining room table awaiting lunch to be brought to her.</p> <p>On 10/12/06 at 12:45 p.m., the resident was observed using her walker to ambulate to the bathroom at the end of the hallway.</p> <p>On 10/12/06 at 12:45 p.m., the resident stated she used her walker for mobility, and she used a commode placed next to her bed during the night.</p> <p>On 10/13/06 at 2:30 p.m., the administrator confirmed that he had not developed an NSA for Resident #1.</p> <p>B. Behavior Management</p> <p>Resident #1's UAI documented the resident had depression, anxiety and a history of occasional aggression or agitation.</p> <p>On 10/12/06 at 12:00 p.m., the facility's daily log was reviewed and documented the following:</p>	R 008	<p><i>• Administrator will Review all incident/accident reports (if any) on a weekly basis, and will document same</i></p> <p><i>Date of corrective action completed on 11-01-06</i></p> <p><i>Robert Williams, ADM.</i></p>		

Bureau of Facility Standards

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R 008	<p>Continued From page 2</p> <p>a). "9/26/06, [time not entered] resident got up twice to use the bathroom...She was very upset she had to use the potty in her room. She bit me on my chest."</p> <p>b). "9/29/06, [7:00 a.m. to 3:00 p.m. shift]... (resident's name) had an argument with her roommate. I heard a loud bang and went into their room, the roommate was on the ground against the door/wall crying. I helped her up..."</p> <p>c). "10/3/06, [11:00 p.m. to 7:00 a.m. shift]... (resident's name) slept all night until 6:00 am. She hit me with the door and said she wishes she could hurt me."</p> <p>d). "10/6/06, [time not entered] (resident's name) was upset through the night because she wouldn't use the potty in her room so she hit me with the door 3 times."</p> <p>On 10/12/06 at 11:45 a.m., the owner/caregiver stated Resident #1 pushed her roommate down onto the floor by pushing her with her walker, and this event happened on 9/29/06.</p> <p>On 10/13/06 at 1:10 p.m., Resident #1's roommate was interviewed. She confirmed that she had been pushed down by Resident #1. She stated, "I'm not sure why she did that to me, I just know that she was angry when she knocked me down with her walker."</p> <p>On 10/13/06 at 2:30 p.m., another caregiver stated, "Resident #1 had some behaviors recently. There was no written plan for how to care for the resident. Staff just talked to her and we tried to find out what she needed, or how we could help her."</p>	R 008			

Bureau of Facility Standards

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R 008	<p>Continued From page 3</p> <p>On 10/13/06 at 2:30 p.m., the administrator confirmed that he had not developed a BMP for Resident #1. There was no written plan giving direction to caregivers on how to intervene when the resident had inappropriate behaviors.</p> <p>The facility did not develop or implement an NSA which would provide guidance to personnel in their provision of care and services to meet the needs of the resident. Additionally, the facility failed to develop a BMP that included all situations that triggered Resident #1's behaviors or interventions to be used to prevent inappropriate behaviors. These failures resulted in inadequate care.</p>	R 008			



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October 26, 2006

FILE COPY

Robert Williams, Administrator
The Haven
1119 West Hudson Avenue
Nampa, ID 83651

Dear Mr. Williams:

On October 13, 2006, a complaint investigation survey was conducted at The Haven. The survey was conducted by Rebecca Winter, R.N. and Karen McDannel, R.N. This report outlines the findings of our investigation.

Complaint # ID00001987

Allegation #1: The facility did not have enough food to follow the facility's menu.

Findings: Based on observation, interview and record review it was determined the facility had sufficient food supplies in the facility to meet the planned menu.

On October 12, 2006 at 11:00 a.m. the facility menu was reviewed, and was found to be nutritional and well balanced.

On October 12, 2006 at 11:11 a.m. the food supply of the facility was observed. The pantry closet shelves were filled with canned and packaged food, and the refrigerator and freezer were filled with perishable food.

On October 12, 2006 at 11:05 a.m. the administrator/owner stated he kept sufficient food within the facility to meet the planned menu.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on October 13, 2006.

Allegation #2: The facility owner had taken the identified resident's walker away to limit mobility.

The resident was forced to lie in bed throughout the day.

Findings: Based on observation, record review and interview it was determined the identified resident had free access to her walker, and was able to choose when to ambulate or rest on the bed.

Review of the identified resident's record revealed the resident was admitted to the facility on July 3, 2006 with diagnoses which included fibromyalgia, hypertension, arthritis, and osteoporosis.

On October 11, 2006 at 1:48 p.m., an adult protection worker stated the identified resident told her she used her walker for mobility.

On October 12, 2006 at 12:45 a.m. the identified resident was observed using her walker to ambulate to the bathroom at the end of the hallway. Staff did not interfere with the resident's ambulation.

On October 12, 2006 at 11:30 a.m. the identified resident stated no one had taken her walker away, and no one forced her to stay in bed.

On October 12, 2006 at 11:45 a.m. the owner/caregiver stated the identified resident always had free access to her walker. Additionally, she stated the resident had a commode by her bed to use at night to better meet her needs.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on October 13, 2006.

Allegation #3. The identified resident was verbally abused by the facility's owner. The facility owner also threw items at the resident.

Findings: Based on observation, interview and record review it was determined the identified resident had not been verbally abused, and the owner did not throw items at her.

Review of the identified resident's record revealed the resident was admitted to the facility on 7/3/06 with diagnoses which included fibromyalgia, hypertension, arthritis, and osteoporosis.

On October 11, 2006 at 1:48 p.m., an adult protection worker stated she had gone out to investigate verbal and physical abuse at the facility. She stated there were no signs of abuse.

On October 12, 2006 at 11:30 a.m. the identified resident stated no one had spoken harshly to her. Further, she stated no one had ever thrown anything at her.

On October 12, 2006 at 11:45 a.m. the owner/caregiver stated she had never spoken

with the intent to abuse any of the residents within her care. Further, she stated she had never thrown anything at any of the residents.

On October 12, 2006 four random residents stated separately no one had ever spoken harshly or abusively to them at any time during their stay at the facility, and they had never seen anyone throw anything at the residents.

On October 13, 2006 at 9:25 a.m. another caregiver, who no longer worked at the facility, stated she never observed the owners verbally abusing any of the residents or throwing items at the residents.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on October 13, 2006.

Allegation #4. The identified resident had been ill and vomiting since August. The facility failed to obtain medical services until the first week in October.

Findings: Based on interview and record review it was determined the identified resident had obtained the needed medical services in a timely manner.

Review of the identified resident's record revealed the resident was admitted to the facility on August 1, 2006 with diagnoses which included coronary artery disease, gastroesophageal reflux disease, dementia, and hypertension.

Further review of the identified resident's record on October 12, 2006 revealed a history and physical from a hospital which documented the resident was admitted there on July 12, 2006. Additionally, the resident's record contained a "doctor's orders and progress note" from the same hospital dated August 1, 2006, which documented the resident was to be discharged from the hospital to the facility.

The identified resident's record also contained notes from another hospital which documented the resident had been seen in the emergency department on two occasions. On September 18, 2006 the resident was treated for a ventral incisional hernia. On September 23, 2006 the resident was treated for abdominal pain and hypertension. During the latter visit he was also diagnosed with an abdominal aortic aneurysm.

On October 12, 2006 at 11:40 a.m. the identified resident stated he was in a hospital for two or three weeks before coming to live at the facility. He also stated he was at another hospital in September where he was treated in the emergency department. Further, he stated he had never vomited while at the facility.

On October 12, 2006 at 1:35 p.m. the owner/caregiver stated she had obtained medical services for the identified resident when he needed it. She said the resident

had had some abdominal pain and he had been diagnosed with a hernia and an aneurysm when she took him to the emergency room.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on October 13, 2006.

Allegation #5. The facility owner assisted residents with medications. She pre-poured the medications before assisting residents with them.

Findings: Based on observation and interview it was determined the owner/caregiver did not pre-pour medications before assisting residents with them.

On October 12, 2006 at 12:15 p.m. the owner/caregiver was observed assisting two residents with their medications. She did not pre-pour medications. She took each resident's group of blister packs one at a time to the residents.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on October 13, 2006.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

A handwritten signature in cursive script that reads "Rebecca Winter".

REBECCA WINTER
Team Leader
Health Facility Surveyor
Residential Community Care Program

RW/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program



ASSISTED LIVING

Non-Core Issues

Punch List

Facility Name	Physical Address	Phone Number
The Haven	1119 West Hudson Ave	461-4232
Administrator	City	ZIP Code
Robert Williams	Nampa	83651
Survey Team Leader	Survey Type	Survey Date
Rebecca Winter	Complaint investigation	10-13-06

NON CORE ISSUES

[illegible]

Response Required Date	Signature of Facility Representative	Date Signed
11-13-06	Robert Williams	10-13-06